FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024745

Facility Name: WINNING WHEELS

Address: 701 E. THIRD STREET (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: 815-537-5168 **Fax #** 815-537-5268

IDPA ID Number: 237136038001

Date of Initial License for Current Owners: 01/01/79

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: ALAN GAPINSKI **Telephone Number:** 815-778-3610

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) ALAN GAPINSKI

(Title) CEO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 80

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,549	2,170	648	6,367	8
9	SNF/PED					9
10	ICF	21,577		0	21,577	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,126	2,170	648	27,944	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.70%

D. How many bed-hold days during this year were paid by Public Aid?
820 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 01/01/79

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 648

Medicare Intermediary ADMINISTRATOR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 6/30/02 Fiscal Year: 6/30/02

* All facilities other than governmental must report on the accrual basi

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	203,915	21,800	5,545	231,260	1,994	233,254		233,254			1
2	Food Purchase		187,133		187,133		187,133	(2,357)	184,776			2
3	Housekeeping	80,281	19,315		99,596	717	100,313		100,313			3
4	Laundry	65,725	16,316		82,041		82,041	(15,852)	66,189			4
5	Heat and Other Utilities			84,865	84,865		84,865		84,865			5
6	Maintenance	85,699	56,767	34,550	177,016	1,275	178,291		178,291			6
7	Other (specify):*											7
8	**TOTAL General Services**	435,620	301,331	124,960	861,911	3,986	865,897	(18,209)	847,688			8
	B. Health Care and Programs											
9	Medical Director			22,500	22,500		22,500		22,500			9
10	Nursing and Medical Records	1,228,068	243,223	9,175	1,480,466	(43,045)	1,437,421		1,437,421			10
10a	Therapy	170,999	3,399	22,367	196,765		196,765		196,765			10a
11	Activities	81,448	13,904	960	96,312		96,312		96,312			11
12	Social Services	68,513			68,513		68,513		68,513			12
13	Nurse Aide Training					54,369	54,369	(16,127)	38,242			13
14	Program Transportation	19,804	11,948		31,752	(21,340)	10,412		10,412			14
15	Other (specify):* SPEECH/COGN	48,337			48,337		48,337		48,337			15
16	**TOTAL Health Care and Programs**	1,617,169	272,474	55,002	1,944,645	(10,016)	1,934,629	(16,127)	1,918,502			16
	C. General Administration											
17	Administrative			203,250	203,250		203,250	(50,656)	152,594			17
18	Directors Fees											18
19	Professional Services			48,890	48,890		48,890	(3,312)	45,578			19
20	Dues, Fees, Subscriptions & Promotion			42,673	42,673		42,673	(9,500)	33,173			20
21	Clerical & General Office Expense	185,460	20,409	24,514	230,383		230,383	(2,014)	228,369			21
22	Employee Benefits & Payroll Taxe			346,338	346,338	(7,975)	338,363	27,447	365,810			22
23	Inservice Training & Educatior			13,399	13,399	(6,060)	7,339	181	7,520			23
24	Travel and Seminar			15,930	15,930		15,930	(4,912)	11,018			24
25	Other Admin. Staff Transportatior							1,124	1,124			25
26	Insurance-Prop.Liab.Malpractice			20,657	20,657		20,657	174	20,831			26
27	Other (specify):*											27
28	**TOTAL General Administration**	185,460	20,409	715,651	921,520	(14,035)	907,485	(41,468)	866,017			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,238,249	594,214	895,613	3,728,076	(20,065)	3,708,011	(75,804)	3,632,207			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WINNING WHEELS #0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation					182,127	182,127	38,618	220,745			30
31	Amortization of Pre-Op. & Org											31
32	Interest			45,043	45,043		45,043	(7,075)	37,968			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			189,952	189,952	(189,952)						36
37	**TOTAL Ownership**			234,995	234,995	(7,825)	227,170	31,543	258,713			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					27,890	27,890		27,890			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			43,800	43,800	27,890	71,690		71,690			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,238,249	594,214	1,174,408	4,006,871		4,006,871	(44,261)	3,962,610			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(2,357)	2		4
5	Telephone, TV & Radio in Resident Room	(5,163)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(15,852)	4		8
9	Non-Straightline Depreciation	34,674	30		9
10	Interest and Other Investment Income	(8,137)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer	(5,938)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee	(16,127)	13		27
28	Yellow Page Advertising	(90)	20		28
29	Other-Attach Schedule	(14,696)	20,24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,686)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(10,575)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (10,575)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (44,261)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport	X		$ 27,890	38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Programs					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 27,890		47

WINNING WHEELS

ID# 0024745

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	FLOWERS	$ (858)	20	1
2	ADVERTISING/MARKETING	(8,926)	20	2
3	OUT OF STATE TRAVEL	(4,912)	24	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,696)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,357)	0	0	0	0	0	0	0	0	0	0	(2,357)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(15,852)	0	0	0	0	0	0	0	0	0	0	(15,852)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,209)	0	0	0	0	0	0	0	0	0	0	(18,209)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	(16,127)	0	0	0	0	0	0	0	0	0	0	(16,127)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(16,127)	0	0	0	0	0	0	0	0	0	0	(16,127)	16
	C. General Administration													
17	Administrative	0	58,670	85,081	3,121	5,722	(203,250)	0	0	0	0	0	(50,656)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,938)	2,149	477	0	0	0	0	0	0	0	0	(3,312)	19
20	Fees, Subscriptions & Promotions	(9,874)	374	0	0	0	0	0	0	0	0	0	(9,500)	20
21	Clerical & General Office Expenses	(5,163)	3,149	0	0	0	0	0	0	0	0	0	(2,014)	21
22	Employee Benefits & Payroll Taxes	0	20,890	0	0	0	0	6,557	0	0	0	0	27,447	22
23	Inservice Training & Education	0	181	0	0	0	0	0	0	0	0	0	181	23
24	Travel and Seminar	(4,912)	0	0	0	0	0	0	0	0	0	0	(4,912)	24
25	Other Admin. Staff Transportation	0	1,124	0	0	0	0	0	0	0	0	0	1,124	25
26	Insurance-Prop.Liab.Malpractice	0	174	0	0	0	0	0	0	0	0	0	174	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(25,887)	86,711	85,558	3,121	5,722	(203,250)	6,557	0	0	0	0	(41,468)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(60,223)	86,711	85,558	3,121	5,722	(203,250)	6,557	0	0	0	0	(75,804)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	34,674	2,325	1,619	0	0	0	0	0	0	0	0	38,618	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,137)	1,062	0	0	0	0	0	0	0	0	0	(7,075)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	26,537	3,387	1,619	0	0	0	0	0	0	0	0	31,543	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(33,686)	90,098	87,177	3,121	5,722	(203,250)	6,557	0	0	0	0	(44,261)	45

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES	0.00%	BIG MEADOWS	SAVANNA	LYNDON PROGRESS		DAYTREATMENT
	0.00%	PLEASANTVIEW	MORRISON	CENTER	LYNDON	REHABILITATION
WINNING WHEELS, INC.	100.00%	STRIVE	PROPHETSTOWN	LYNDON PLAY &		
				LEARN CENTER	LYNDON	CHILD DAYCARE
				FRONTIER HOLLOW		INDEPENDENT
				APARTMENTS	PROPHETSTOWN	LIVING FACILITY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		DAYCARE BENEFITS	$ 16,196	LYNDON PLAY & LEARN	100.00%	$ 22,753	$ 6,557	1
2	V								2
3	V		PROFESSIONAL SERVICES	203,250	AMERICAN HEALTH ENTERPRISES		186,118	(17,132)	3
4	V				MANAGEMENT COMPANY				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 219,446			$ 208,871	$ * (10,575)	14

* Total must agree with the amount recorded on line 34 of Schedule VI

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	AMERICAN HEALTH ENTERPRISES, INC.								$		1
2	ALAN GAPINSKI	PRESIDENT	DIRECT MANAGEMENT								2
3	(100% OWNER - AHE, INC)										3
4								MANAGEMENT			4
5	WINNING WHEELS, INC			0.00		16	32.00	FEES	203,250	17/3	5
6	S.T.R.I.V.E.			0.00		8	16.00	"	103,750		6
7	BIG MEADOWS, INC.			100.00		10	20.00	"	123,673		7
8	PLEASANT VIEW			100.00		10	20.00	"	112,577		8
9	OTHERS (NON-COST REPORTING)					6	12.00	"	118,330		9
10											10
11											11
12											12
13								TOTAL	$ 661,580		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi
or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization AMERICAN HEALTH ENTERPRISES, INC.
Street Address 501 6TH AVE. WEST
City / State / Zip Code LYNDON, IL 61261
Phone Number (815-778-3683
Fax Number (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 58,670	$ 58,670	1	$ 58,670	1
2	17	ADMINISTRATIVE	GROSS REVENUE	10,444,000	5	252,152	252,152	3,524,000	85,081	2
3	17	ADMINISTRATIVE	DIRECT COST	1	1	3,121	3,121	1	3,121	3
4	17	ADMINISTRATIVE	GROSS REVENUE	10,444,000	5	16,959	16,959	3,524,000	5,722	4
5	19	DATA PROCESSING	GROSS REVENUE	10,444,000	5	6,368	0	3,524,000	2,149	5
6	19	ACCOUNTING	GROSS REVENUE	10,444,000	5	1,414	0	3,524,000	477	6
7	20	DUES,FEES,SUBSCRIPTIONS	GROSS REVENUE	10,444,000	5	1,108	0	3,524,000	374	7
8	21	SUPPLIES,PHONE	GROSS REVENUE	10,444,000	5	9,334	0	3,524,000	3,149	8
9	23	TRAINING, SEMINAR	GROSS REVENUE	10,444,000	5	537	0	3,524,000	181	9
10	25	ADMIN. TRANSPORTATION	GROSS REVENUE	10,444,000	5	3,332	0	3,524,000	1,124	10
11	26	INSURANCE	GROSS REVENUE	10,444,000	5	516	0	3,524,000	174	11
12	22	BENEFITS	% OF SALARY	483,938	5	70,379	0	143,645	20,890	12
13	30	DEPR'N VEHICLES	GROSS REVENUE	10,444,000	5	6,892	0	3,524,000	2,325	13
14	30	DEPR'N EQUIPMENT	GROSS REVENUE	10,444,000	5	4,799	0	3,524,000	1,619	14
15	32	INTEREST VEHICLES	GROSS REVENUE	10,444,000	5	3,146	0	3,524,000	1,062	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 438,727	$ 330,902		$ 186,118	25

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FARMERS NATIONAL BANK		X	MORTGAGE	$13,500.00	10/13/00	$ 750,000	$ 610,198	10/13/2006	6.1500	$ 45,043	1
2												2
3												3
4	AMCORE BANK - RELATED		X	VEHICLES	$624.50	1/2001	30,000	24,856	1/2006	9.0000	1,062	4
5	PARTY ALLOCATION											5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$14,124.50		$ 780,000	$ 635,054			$ 46,105	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 780,000	$ 635,054			$ 46,105	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE Line #

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2001 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru	$	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINNING WHEELS COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0024745

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior MASONARY Frame CONCRETE BLOCK Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING SITE	504,424	1973	$ 23,500	1
2					2
3	TOTALS	504,424		$ 23,500	3

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1979	1979	$ 1,526,858	$ 16,983	VARIOUS	$ 50,895	$ 33,912	$ 1,267,708	4
5			1979	1979	22,848		5	762	762	22,848	5
6			1979	1979	3,826		20			3,826	6
7			1985	1985	4,226	211	20	211	(0)	3,651	7
8			1987	1987	11,212	561	20	561	0	8,736	8
	Improvement Type**										
9	TILE FLOOR			1985	585	29	20	29		488	9
10	AIR CONDITIONER-KITCHEN			1986	1,367		10			1,367	10
11	AIR CONDITIONER-COMPRESSOR			1986	2,576		10			2,576	11
12	CON			1986	2,093	105	20	105		1,631	12
13	LAVATORIES			1987	780	39	20	39		601	13
14	PATIO			1987	3,089	154	20	154		2,342	14
15	TRACK CURTAIN SYSTEM			1987	1,306	65	20	65		990	15
16	CEDAR / POST RAILS			1987	230		10			230	16
17	SHOWER DOORS			1987	350	25	15	25		350	17
18	BLACKTOP PATH			1987	5,946	297	20	297		4,336	18
19	BATH IMPROVEMENTS			1988	11,342	756	15	756		10,964	19
20	TV ANTENNA BOOSTER			1988	455		10			455	20
21	FAUCETS			1988	597	40	15	40		573	21
22	HEAT A/C UNIT			1988	2,869	191	15	191		2,757	22
23	MOTORS			1988	1,037		10			1,037	23
24	EMPLOYEE LOUNGE			1988	3,235	162	20	162		2,319	24
25	DOOR OPENERS			1988	3,505	234	15	234		3,349	25
26	BATH PARTITIONS			1988	764		10			764	26
27	BLACKTOP			1988	5,023	335	15	335		4,576	27
28	COUNTERTOP / SHELVES			1988	1,678	112	15	112		1,528	28
29	FITNESS TRAIL			1988	945		5			945	29
30	PARKING LOT SEALER			1988	4,000		4			4,000	30
31	BACK ROOM RENOVATIONS			1988	30,717	2,048	15	2,048		27,987	31
32	SIGNAGE			1988	872	44	20	44		596	32
33	HEATER MOTORS/ THERMOSTAT			1988	1,010		5			1,010	33
34	LANDSCAPING			1989	4,715		10			4,715	34
35	BLACKTOP ROCK & SEALING			1989	5,906	394	15	394		5,053	35
36	DRAPES			1989	1,083		10			1,083	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BATHROOM REMODELING	1990	$ 11,976	$		$	$	$ 11,976	37
38	WATER SOFTENER	1990	5,858	488		488		5,858	38
39	SIGN	1990	3,700	308		308		3,623	39
40	PARKING LOT LIGHTS	1990	6,258	417		417		5,073	40
41	SHRUBS	1990	1,235	82		82		995	41
42	CARPET	1990	2,669					2,669	42
43	BATHROOM IMPROVEMENTS	1991	12,802	853		853		9,601	43
44	WANDERGUARD	1991	2,772					2,772	44
45	AUTOMATIC DOOR OPENERS	1991	4,455	260		260		4,455	45
46	REMODEL DINING ROOM	1992	34,562	1,728		1,728		17,281	46
47	REMODEL A & B WINGS	1992	18,929	946		946		9,149	47
48	NEW HOTWATER BOILER	1992	4,272	285		285		2,729	48
49	RT CLINIC	1993	2,992	150		150		1,384	49
50	FLOWER BED	1993	1,142	114		114		1,038	50
51	LIGHTS & VENT KITCHEN	1993	3,777	189		189		1,716	51
52	ENGR & ARCHITECT LAUNDRY	1993	3,735	187		187		1,681	52
53	WATER HEATER & COND LAUNDRY	1993	4,813	321		321		2,887	53
54	BLINDS & VALENCES LOBBY & OFFICE	1993	3,295	330		330		2,938	54
55	LAUNDRY ROOM	1993	28,023	1,401		1,401		12,143	55
56	INTERIOR SIGN	1994	900	82		82		695	56
57	COUNTER TOPS RT CLINIC	1994	1,283	64		64		545	57
58	REDECORATE LOBBY	1994	29,817	1,491		1,491		12,424	58
59	GAS WATER HEATER	1994	2,149	143		143		1,170	59
60	REPLACE ROOF ON SHELTER	1994	514	34		34		277	60
61	REDECORATE OFFICE	1994	1,587	159		159		1,283	61
62	REDECORATE ROOMS & HALLS	1994	11,264	1,126		1,126		9,011	62
63	SHRUBS & PLANTS	1994	7,501	750		750		5,938	63
64	PATIO	1994	8,723	582		582		4,604	64
65	CARPETING	1994	680					680	65
66	COUNTER TOPS RT CLINIC	1994	1,241	62		62		486	66
67	DOOR ALARM SYSTEM	1994	6,962	663		663		6,962	67
68	DECORATION DINING	1995	1,870	187		187		1,403	68
69	ACCORDIAN DOORS	1995	12,071	604		604		4,476	69
70	TOTAL (lines 4 thru 69)		$ 1,910,869	$ 36,791		$ 71,465	$ 34,674	$ 1,545,311	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forwarc		$ 1,910,869	$ 36,791		$ 71,465	$ 34,674	$ 1,545,311	1
2	AIR CONDITIONER	1995	3,575	358		358		2,532	2
3	NEW ROOF A & B WINGS	1995	42,900	2,145		2,145		15,015	3
4	GARAGE 24' X 58'	1995	27,086	1,354		1,354		9,029	4
5	SWING DOOR OPERATOR	1996	4,246	425		425		2,760	5
6	WIRING FOR NEW GARAGE	1996	3,384	226		226		1,467	6
7	CARPETING	1996	811					811	7
8	GARAGE DOOR	1996	1,519	76		76		494	8
9	HEATER	1996	1,506	100		100		644	9
10	WALLPAPER	1996	471	47		47		302	10
11	CEILING TILE	1996	4,157	208		208		1,334	11
12	WALLPAPER BACK OFFICE	1996	587	59		59		377	12
13	FLOORING	1996	425	21		21		136	13
14	TILING FOR FLOORING	1996	4,105	205		205		1,300	14
15	GREY FLOOR GROUT	1996	237	12		12		74	15
16	STAIRS	1996	200	20		20		125	16
17	REMODEL KITCHEN	1996	13,551	678		678		4,235	17
18	CORNER PROTECTORS	1996	2,200	220		220		1,375	18
19	CARPET - DIETARY & MAIN	1996	415	28		28		415	19
20	COMPRESSOR FOR A/C	1996	6,500	650		650		3,629	20
21	CARPET - DIETARY & MAIN	1996	415	76		76		415	21
22	LAYING BRICK	1996	768	38		38		214	22
23	GARAGE DOOR	1996	667	33		33		186	23
24	BLACKTOP	1996	8,260	551		551		3,074	24
25	DISPOSAL	1996	950	63		63		354	25
26	CARPETING	1997	2,255	414		414		2,255	26
27	FAUCETS	1997	738	49		49		275	27
28	PAINTING	1997	1,948	195		195		1,088	28
29	TILING FOR FLOORING	1997	18,869	943		943		5,267	29
30	LANDSCAPING	1997	1,480	148		148		826	30
31	SOFFIT	1997	4,495	225		225		1,049	31
32	SOFFIT ADDITION	1997	952	48		48		242	32
33	A/C COMPRESSOR AND CONTROLLER	1997	10,811	1,081		1,081		4,955	33
34	TOTAL (lines 1 thru 33)		$ 2,081,352	$ 47,486		$ 82,160	$ 34,674	$ 1,611,566	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,081,352	$ 47,486		$ 82,160	$ 34,674	$ 1,611,566	1
2	DINING ROOM IMPR-GLASS	1997	973	49		49		231	2
3	FOLDING ROOM WALL/DOORS	1998	5,099	255		255		1,147	3
4	FLOORING	1998	2,642	264		264		1,211	4
5	ALARM INSTALLATION	1998	952	95		95		436	5
6	CABINETS	1998	7,745	387		387		1,678	6
7	3.5 TON A/C	1998	1,257	126		126		513	7
8	NATURE TRAIL LANDSCAPING	1998	18,965	1,897		1,897		6,954	8
9	HALLWAY REPAINTING	1998	1,285	129		129		471	9
10	DUMPSTER PAD AND FENCING	1998	1,873	375		375		1,343	10
11	328 FT POLYVINYL FENCING	1999	2,375	119		119		386	11
12	GAZEBO	1999	8,200	410		410		1,333	12
13	FLOORING	1999	5,553	555		555		1,759	13
14	DINING ROOM REMODEL	1999	6,724	672		672		2,129	14
15	ABOVE GROUND TANK	1999	14,566	1,457		1,457		4,613	15
16	LANDSCAPING	1999	6,091	870		870		2,755	16
17	SECURITY SYSTEM UPGRADE	1999	5,472	782		782		2,410	17
18	GAZEBO INSTALLATION	1999	1,998	100		100		308	18
19	FRONT LIGHT FIXTURES	1999	4,507	451		451		1,127	19
20	STORM WATER PUMP	1999	2,404	343		343		859	20
21	PARKING LOT	1999	13,819	1,382		1,382		3,455	21
22	KITCHEN AND DINING AREA ROOFING	1999	41,800	2,787		2,787		7,199	22
23	BREAKROOM FLOORING	2000	1,293	185		185		462	23
24	BUG BLOWER	2000	1,265	127		127		316	24
25	CARPET IN MULTI-SENSORY ROOM	2000	4,597	919		919		1,839	25
26	MULTI-SENSORY ROOM	2000	14,966	379		379		695	26
27	INDEPENDENT WAY GARDEN	2000	34,023	1,701		1,701		2,835	27
28	THERAPY ANNEX	2000	1,046,330	26,489		26,489		44,149	28
29	NURSE STATION	2001	17,475	448		448		448	29
30	DOCTOR OFFICE TILE	2001	822	41		41		41	30
31	ENTRYWAYS TILE	2001	1,022	51		51		51	31
32	DIETARY ROOM TILE	2001	1,064	53		53		53	32
33	ROOM C#1 & C#2 TILE	2001	1,234	62		62		62	33
34	TOTAL (lines 1 thru 33)		$ 3,359,745	$ 91,444		$ 126,118	$ 34,674	$ 1,704,833	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 567,537	$ 63,047	$ 63,047	$	VARIOUS	$ 316,700	71
72	Current Year Purchases	79,417	9,929	9,929		VARIOUS	9,929	72
73	Fully Depreciated Assets	415,232					415,232	73
74	RELATED PARTY ALLOCATION			1,619	1,619			74
75	TOTALS	$ 1,062,186	$ 72,976	$ 74,595	$ 1,619		$ 741,861	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRANSPORTATI	VARIOUS	VARIOUS	$ 249,492	$ 21,433	$ 21,433	$	VARIOUS	$ 161,448	76
77	SNOW REMOVAL	2000 DODGE PICKUP	2001	24,985	2,825	2,825		5	2,825	77
78	MEDICALLY NECESSARY	RECLASS				(6,550)	(6,550)			78
79	RELATED ORGANIZATION		VARIOUS			2,325	2,325			79
80	TOTALS			$ 274,477	$ 24,258	$ 20,033	$ (4,225)		$ 164,273	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,719,907	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 188,678	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 220,746	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 32,068	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,610,967	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training wa not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	210	600	1,200	2,010
3	Classroom Wages (a)	2,856	16,320		19,176
4	Clinical Wages (b)		8,160		8,160
5	In-House Trainer Wages (c)	2,191	6,260	12,522	20,973
6	Transportation				
7	Contractual Payments	167	478	955	1,600
8	Nurse Aide Competency Tests		1,000	1,450	2,450
9	TOTALS	$ 5,424	$ 32,818	$ 16,127	$ 54,369
10	SUM OF line 9, col. 1 and 2 (e)	$ 38,242			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$ 11,472

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	20
2. From other facilities (f)	29
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	11
TOTAL TRAINED	67

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit
(b) Include wages paid during the clinical portion of training. Do not include fringe benefit
(c) For in-house training programs only. Do not include fringe benefit
(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8
(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LABORATORY & X-I	10,3 10,3			5 25	486 885		5 25	486 885	13
14	TOTAL			$	30	$ 1,371	$	30	$ 1,371	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 524,136	$ 580,868	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 76,356 / 95,963)	603,701	1,065,309	3
4	Supply Inventory (priced at COST)	35,134	49,137	4
5	Short-Term Investments	1,214,519	2,070,081	5
6	Prepaid Insurance	11,365	13,129	6
7	Other Prepaid Expenses	12,763	15,395	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ATTACHED	70,222	313,579	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,471,840	$ 4,107,498	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500	272,861	13
14	Buildings, at Historical Cost	3,336,896	7,030,868	14
15	Leasehold Improvements, at Historical Cost		151,205	15
16	Equipment, at Historical Cost	1,336,663	1,920,081	16
17	Accumulated Depreciation (book methods)	(2,588,120)	(3,384,408)	17
18	Deferred Charges	3,825	8,313	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROGRESS		26,732	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,112,764	$ 6,025,652	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,584,604	$ 10,133,150	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 48,518	$ 58,151	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	128,042	1,682,586	29
30	Accrued Salaries Payable	151,854	179,570	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,028	49,698	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	STRIVE REVENUE BOND		18,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 363,442	$ 1,988,005	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	482,156	482,156	40
41	Bonds Payable		178,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Reserve Fund		(11,610)	43
44	PA Advance for DT		49,029	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 482,156	$ 697,575	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 845,598	$ 2,685,580	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,739,006	$ 7,447,570	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,584,604	$ 10,133,150	48

***(See instructions.)**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,771,425	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,771,425	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(4,587)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) SUBSIDIARY COMPANIES		15	
16	Other (describe) NET INCOME	680,732	16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 676,145	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,447,570	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 3,906,700	1
2	Discounts and Allowances for all Level	(12,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,894,700	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement	29,107	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,357	14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	15,852	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 47,316	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	8,137	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,137	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	52,131	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 52,131	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,002,284	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	861,911	31
32	Health Care	1,944,645	32
33	General Administratior	921,520	33
	B. Capital Expense		
34	Ownership	234,995	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	43,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,006,871	40
41	**Income before Income Taxes (line 30 minus line 40)****	(4,587)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (4,587)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,084	2,200	$ 44,916	$ 20.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,039	9,706	182,206	18.77	3
4	Licensed Practical Nurses	10,599	11,194	180,938	16.16	4
5	Nurse Aides & Orderlies	68,285	71,137	743,326	10.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,820	1,900	24,336	12.81	9
10	Activity Assistants	4,575	4,803	57,113	11.89	10
11	Social Service Worker	5,373	5,541	68,513	12.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,000	2,080	24,865	11.95	14
15	Cook Helpers/Assistants	21,765	22,829	179,050	7.84	15
16	Dishwashers					16
17	Maintenance Worker	8,200	9,048	85,699	9.47	17
18	Housekeepers	8,572	9,112	80,281	8.81	18
19	Laundry	10,024	10,731	65,725	6.12	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,293	14,044	185,460	13.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,940	2,092	25,251	12.07	31
32	Other Health Care(specify)	16,371	17,640	290,570	16.47	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	183,940	194,057	$ 2,238,249 *	$ 11.53	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	111	$ 5,545	1,3	35
36	Medical Director	180	22,500	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	2,400	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan	7	145	10a,3	41
42	Respiratory Therapy Consultan	4	220	10a,3	42
43	Speech Therapy Consultant	419	20,950	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) MUSIC THERAPY	24	960	11,3	46
47	PSYCHIATRIC EVALS	14	1,052	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	819	$ 53,772		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	197	5,404	10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	197	$ 5,404		53

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ELIZABETH GOODMAN	ADMINISTRATOR	NONE	
(SALARY INCLUDED IN MANAGEMENT FEES - LINE 17 COL. 3)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES, INC.	203,250
TOTAL (agree to Schedule V, line 17, col. 3)	203,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
WARD, MURRAY, PACE	LEGAL	6,481
LINDGREN, CALLIHAN, VANOSI	AUDIT FEES	12,718
POLARIS	MEDICARE CONSULTANT	8,111
JOHN PYSE	COMPUTER CONSULTANT	5,779
COMPUTER INTEGRATION	WEB SITE/EMAIL HOST	4,049
CREATIVE SOLUTIONS	MEDICAL RECORDS SOFTW	3,117
MIDWEST AUTO TIME	TIME SYSTEM SOFTWARE	630
"IVANS" DIAL UP FEES	MEDICARE BILLING	728
BKD, LLP	MEDICARE COST REPORT	1,093
ACHIEVE/UNISOFT/INGENIX	SOFTWARE MAINT. FEES	5,764
MILLER, LANCASTER	ATTORNEY LETTER-AUDIT	225
HEYL, ROYSTER	ATTORNEY LETTER-AUDIT	195
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		48,890

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	47,140
Unemployment Compensation Insurance	
FICA Taxes	166,046
Employee Health Insurance	53,119
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	9,028
RETIREMENT	9,675
ST & LT DISABILITY	20,067
PHYSICALS	827
CHILD CARE	16,197
RELATED PARTY ALLOCATION	27,447
EMPLOYEE MISC BENEFITS	16,263
TOTAL (agree to Schedule V, line 22, col.8)	365,810

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	
Advertising: Employee Recruitment	22,940
Health Care Worker Background Check	
(Indicate # of checks performed 85)	850
IHCA	3,277
CARF	320
OTHER DUES, FEES, BOOKS	7,396
SUBSCRIPTIONS & DUES	7,890
RELATED PARTIES ALLOCATION	374
Less: Public Relations Expense	(4,307)
Non-allowable advertising	(5,477)
Yellow page advertising	(90)
TOTAL (agree to Sch. V, line 20, col. 8)	33,173

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	5,990
OUT OF STATE - DISALLOWED	(4,912)
In-State Travel	6,338
Seminar Expense	3,602
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	11,018

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING	07/2001	$ 6,373	5 YRS	$	$	$ 1,275	$ 1,275	$ 1,275	$ 1,275	$ 1,273	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,373		$	$	$ 1,275	$ 1,275	$ 1,275	$ 1,275	$ 1,273	$	$

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/01 Ending: 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **NO**

(2) Are there any dues to nursing home associations included on the cost repor **YES**
If YES, give association name and amount **ILL HEALTH CARE ASSOC. $3277**

(3) Did the nursing home make political contributions or payments to a politic
action organization? **NO** If YES, have these cost
been properly adjusted out of the cost report

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year **NO** If YES, what is the capacity

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this perio **6.7yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **13,035** Line **10**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports **YES** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **NO**
If YES, give effective date of leas

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **43,800**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee **NO** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **YES**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **NONE** Has any meal income been offset agains
related costs? **YES** Indicate the amount $ **2,357**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **NO**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **YES** If YES, please indicate the amount of income earned from such
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patient **100%**
d. Have vehicle usage logs been maintained **YES**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use **YES**
f. Has the cost for commuting or other personal use of autos been adjust
out of the cost report **N/A**
g. Does the facility transport residents to and from day training YES
Indicate the amount of income earned from providing suc
transportation during this reporting period $ NONE

(17) Has an audit been performed by an independent certified public accounting firm **YES**
Firm Name: **LINDGREN, CALLIHAN, VANOSDOL, CPA'S** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? **YES** If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **YES**
Attach invoices and a summary of services for all architect and appraisal fee